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W 120	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3) The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure outside services met the needs of 1 of 4 audit client (#6). Specifically the behavior support plan (BSP) was not shared with the school. The finding is: Client #6's BSP; relevant emerging behaviors or other important information was not provided to the school. Interview on 1/13/20 with 3 high school teachers revealed no behavior support plan or individual program plan (IPP) was provided to them this year. Furthermore, all teachers interviewed indicated they are not confident that the home shares information that may be relevant with them. For example, the school indicated sometimes a bruise appears on a child and they have no idea if the home has seen the bruise or if they have not. The teachers indicated that while they invited the home to the individual education program (IP) meetings, they have not been invited to the homes individual program plan (IPP) meetings. Further interview on 1/13/20 revealed the school has no knowledge of any emerging sexual behaviors and that client #6 walks independently between classes and to the bathroom. Interview on 1/13/20 with the qualified intellectual disabilities professional (QIDP) revealed that he	W 120		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 120	Continued From page 1 felt he provided sufficient information to the school but he confirmed he had not provided a BSP or IPP this year. He further confirmed that he had not told the school about the incident of finding client #6 naked with a peer and the information client #6 gave them about what sexually he was trying to do to his peer.	W 120		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to assure all officials were notified immediately of an incident. This potentially affected 1 of 4 audit client (#5). The finding is: The facility failed to notify the law enforcement agency and health care personnel of an incident of potential sexual abuse During a review of client #5's record on 1/13/20, a core team dated 8/12/19 revealed "inappropriate sexual contact with a peer." The core team noted an increase in monitoring but not any more details. Review of the facility investigation revealed client #5 was "missing" so a search of the home was conducted. At that time, client #6's door was	W 153		

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W 153	Continued From page 2 found to be locked. The staff obtained a key to unlock it. The staff statement revealed before the staff could put the key in the door to unlock it client #5 opened client #6's door. The report indicated client #6 stated he penetrated client #5 in his behind and then he said he "tried" but did not. He was taken to the hospital but no IRIS report including notification of law enforcement was found. There was no discussion of notification of the school. Interview with the facility qualified intellectual disability professional (QIDP) on 1/14/20 confirmed that the IRIS with law enforcement notification could not be located. He further indicated that the school notification had been discussed but not documented and they opted not to inform the school. The psychologist confirmed this.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure a thorough investigation of all incidents and elopements. This potentially affected all clients residing in the facility. The finding is: Two (2) incidents (one of elopement and one of a possible sexual encounter) were not thoroughly investigated by the facility. During a review of client #5's record on 1/13/20, a	W 154		

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core team meeting dated 7/9/19 revealed an elopement /AWOL had occurred. The team meeting also noted that 15 minute checks would be added to his program as well as alarms added to his windows and modifications made to the back fence. However, the core teamt did not indicate where he eloped to; how long he was gone; where staff was when it happened etc.

Interview with management on 1/13/20 confirmed client #5's elopement happened but was not investigated.

During further review of client #5's record on 1/13/20, a core team dated 8/12/19 revealed "inappropriate sexual contact with a peer." The core team noted an increase in monitoring but not any more details.

Review of the facility investigation revealed client #5 was "missing" so a search of the home was conducted. At that time, client #6's door was found to be locked. The staff obtained a key to unlock it. The staff statement revealed before the staff could put the key in the door to unlock it, client #5 opened client #6's door. The report indicated client #6 stated he penetrated client #5 in his behind and then he said he "tried" but did not. He was taken to the hospital but no IRIS report including notification of law enforcement was found. There was no discussion of notification of the school. The recommendation was for the psychologist to remove "M" games from client #5's collection.

Further interview with the facility QIDP on 1/14/20 confirmed that the IRIS with law enforcement notification could not be located. He further indicated that the school notification had been

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W 154	Continued From page 4 discussed but not documented and they opted not to inform the school. The psychologist confirmed this. The QIDP confirmed without the notifications and discussion the investigation is not thorough. The inappropriate sexual behavior was added to a BSP. Further interview with the QIDP on 1/14/20 confirmed the elopement(s) were never investigated. The psychologist confirmed this behavior remains addressed by a behavior support plan.	W 154		
W 156	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to assure all officials were notified within five working days of an incident. This potentially affected 1 of 4 audit client (#5). The finding is: The facility failed to notify the law enforcement agency and health care personnel of an incident of potential sexual abuse During a review of client #5's record on 1/13/20, a core team dated 8/12/19 revealed "inappropriate sexual contact with a peer." The core team noted an increase in monitoring but not any more details.	W 156		

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W 156	Continued From page 5 Review of the facility investigation revealed client #5 was "missing" so a search of the home was conducted. At that time, client #6's door was found to be locked. The staff obtained a key to unlock it. The staff statement revealed before the staff could put the key in the door to unlock it client #5 opened client #6's door, The report indicated client #6 stated he penetrated client #5 in his behind and then he said he "tried" but did not. He was taken to the hospital but no IRIS report including notification of law enforcement was found. There was no discussion of notification of the school. Interview with the facility qualified intellectual disability professional (QIDP) on 1/14/20 confirmed that the IRIS with law enforcement notification could not be located. He further indicated that the school notification had been discussed but not documented and they opted not to inform the school. The psychologist confirmed this.	W 156		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure the qualified intellectual disability professional (QIDP) coordinated, integrated and monitored the active treatment program for 1 of 4 audit clients (#6). The finding is: The QIDP did not assure the school knew about an incident of sexually inappropriate behavior and provide a copy of the behavior support program	W 159		

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(BSP).

During a review of client #5's record on 1/13/20, a core team dated 8/12/19 revealed "inappropriate sexual contact with a peer." The core team noted an increase in monitoring but not any more details.

Review of the facility investigation revealed client #5 was "missing" so a search of the home was conducted. At that time, client #6's door was found to be locked. The staff obtained a key to unlock it. The staff statement revealed before the staff could put the key in the door to unlock it client #5 opened client #6's door. The report indicated client #6 stated he penetrated client #5 in his behind and then he said he "tried" but did not. He was taken to the hospital but no IRIS report including notification of law enforcement was found. There was no discussion of notification of the school.

Interview with the facility qualified intellectual disability professional (QIDP) on 1/14/20 confirmed that the IRIS with law enforcement notification could not be located. He further indicated that the school notification had been discussed among management but they did not want to notify the school and the discussion was not documented. The psychologist confirmed this. However, the inappropriate sexual behavior was added to a BSP.

Interview with the school on 1/14/20 revealed the teachers had not been provided with copies of the BSP. Furthermore, the teacher for client #5 revealed she was not aware of any inappropriate sexual behaviors or emerging sexual behaviors. She was not aware of client #5 ever attempting to

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W 159	Continued From page 7 touch anyone inappropriately. She stated she hoped the home management would notify the school of any such emerging behaviors. She also indicated client #5 is not monitored at all times and he is independent at walking to classes and to the bathroom.	W 159		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure all medications were given as ordered. This affected 1 of 4 audit clients (#5). The finding is: One medication was not given at the dose it was ordered. During observations of the medication pass on 1/14/20 at 5:50am, client #5 was given Topamax 50 mg among other medications. After the observation on 1/14/20, the physician's orders signed 1/7/20 revealed, "Topamax 25 mg, Take 1 tablet by mouth twice a day 6:30 am." Interview with the nurse via phone on 1/14/20 revealed that the wrong order must be in the record. However, the QIDP confirmed there is no current order for Topamax 50 mg in the record. Note: After the survey the nurse revealed a fax copy of an order for Topamax 50 mg but the date	W 369		

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W 369	Continued From page 8 is not legible but appears to be 1/7/19 (not 2020).	W 369		
W 418	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(ii) The facility must provide each client with a clean, comfortable mattress. This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility did not provide 1 of 4 audit clients (#4) a mattress, in good condition. The finding is: Client #4's mattress was lopsided. During observations in the home on 1/13/20 and 1/14/20, client #4's mattress had a noticeable upward tilt at the bottom of the bed. An interview with Staff E on 1/14/20 revealed that client #4 had needed several mattresses replaced over the years because client would jump up and down on the bed like a trampoline. During a conversation with the qualified intellectual disabilities professional (QIDP) on 1/14/20, regarding the condition of client #4's mattress, he offered no explanation if anyone monitored the conditions of furnishings.	W 418		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.	W 436		

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W 436	Continued From page 9 This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to furnish eyeglasses for 1 of 4 audit clients (#3). The finding is: Client #3 was prescribed single lenses eyeglasses. During observations in the home and at school, on 1/13/20-1/14/20, client #3 did not wear eyeglasses. During review on 1/13/20 of a vision exam dated 12/17/19, it was noted that client #3 was prescribed glasses, to "make things clearer." Client #3 did not need to wear the glasses full time. An additional review on 1/14/20 revealed that client #3's individual program plan (IPP) dated 12/30/19 had implemented a training goal on 1/9/20 to help client tolerate wearing his eyeglasses, with a graduated wear schedule. It was noted that the program would start, once client #3 received his eyeglasses. During an interview with the qualified intellectual disabilities professional (QIDP) on 1/14/20 he stated that client #3 was not taken to get eyeglasses yet because they had to get his Medicaid squared away, due to him using multiple names.	W 436		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1)	W 460		

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Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.

This STANDARD is not met as evidenced by:
Based on observations, record review and staff interviews, the facility failed to provide the proper diet consistency for 3 of 4 audit clients (#1, #3 and #5). The findings are:

1. Clients #1 and #3 food was not cut up into bite size pieces.

a. During observations in the home on 1/13/20 at 5:15 pm, Client #1 was served chunky pieces of beef tips with gravy and cooked carrot slices, the size of quarters. The food was not cut into 1/2 inch pieces before consumed.

Review on 1/13/20 of Client #1's individual program plan (IPP) dated 5/15/19 revealed that he was on a regular diet with 1/2 inch bite size pieces.

b. During observations in the home on 1/13/20 at 5:15 pm, Client #3 was served chunky pieces of beef tips with gravy and cooked carrot slices, the size of quarters. The food was not cut into 1/4th of an inch pieces before consumed.

Review on 1/13/20 of Client #3's individual program plan (IPP) dated 12/30/19 revealed that he was on a regular diet with 1/4th of an inch bite size pieces.

During an interview on 1/14/20 with the qualified intellectual disabilities professional (QIDP), confirmed clients # 1 should have a cut diet (1/2

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W 460	Continued From page 11 inch pieces.) and client #3 should have a cut diet (1/4 inch pieces). 2. Client #5's food was not consistently cut into 1/2 bite size pieces. Observations of dinner on 1/14/20, revealed that client #5 had large round cuts of carrots and large pieces of beef. He ended up making a beef sandwich. Additionally, at breakfast he had whole toast, eggs and strips of bacon and began eating without any assistance in cutting his food items. Interview with the QIDP on 1/14/20 confirmed client #5 should have a cut diet (1/2 inch pieces.)	W 460		